ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS

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Federal Communications Commission
445 12th Street SW
Washington, DC 20554

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FCC 19-64

The Association of State and Territorial Health Officials (ASTHO) thanks the Federal Communications Commission for the opportunity to provide comment regarding the notice of proposed rule-making, "Promoting Telehealth for Low-Income Consumers" (Docket No. FCC-18-112). ASTHO is the national nonprofit organization representing public health officials and the agencies they lead in the 50 states, the U.S. territories and freely associated states, and the District of Columbia, as well as the more than 100,000 public health professionals these agencies employ. ASTHO's members, the chief health officials of these jurisdictions, formulate and influence public health policy and ensure excellence in state-based public health practice.

ASTHO affirms the significant value of telehealth services in light of the experience and evidence that demonstrates that telehealth (1) expands and improves access to public health programs and health care services, including preventive and specialty care, (2) addresses health provider workforce shortages and reduces transportation barriers in rural and underserved communities, and (3) has the potential to save costs.[1,2,3,4] State and territorial health officials (S/THOs) and their state and territorial health agency (S/THA) staff have a critical role to play in developing statewide telehealth policy and implementing telehealth programs.

Although the adoption of telehealth has increased in recent years, many regions and individuals still lack reliable broadband internet access connectivity and are unable to reap the benefits of telehealth. Expanding access to broadband for those regions that do not currently have it is a fundamental component of promoting the adoption of telehealth that ASTHO supports.

Below, please find ASTHO's comments on specific provisions of the proposed FCC rule.

Sec. 8. Health Conditions of Focus
The proposed rule suggests limiting the Pilot program to projects that primarily focus on health conditions that typically require at least several months or more to treat—such as behavioral and mental health, opioid dependency, chronic health conditions (e.g., diabetes, kidney disease, heart disease, stroke recovery), and high-risk pregnancies. The Commission believes that collecting data across at least several months would provide more meaningful, statistically significant data to track health outcomes and cost savings.

ASTHO Comment:
ASTHO supports the implementation of a Pilot program that would prioritize behavioral and

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mental health, opioid dependency, chronic health conditions, and high-risk pregnancies. Prioritizing these health conditions would be an efficient and effective use of the Pilot program funds; collecting data across several months would result in meaningful data necessary to determine changes in health outcomes and cost impact. In ASTHO's 2019 telehealth capacity survey, ASTHO collected data from 39 S/THAs, including information on state-identified priority health conditions and current telehealth activities. Results showed that 94 percent of states reported a desire to expand behavioral health telehealth services in their jurisdictions, and 81 percent reported a desire to expand chronic disease services through telehealth. These responses indicate a need for more behavioral health and chronic disease services delivered through telehealth.

Sec. 9. Definition of "Health Condition"
The proposed rule asks whether the Commission should adopt a specific definition of "health condition" for the purposes of the Pilot program and whether there is a generally accepted authority that provides a definition of "health condition" that would be appropriate for the Pilot program to adopt.

ASTHO Comment:
The Affordable Care Act, Section 2703 (1945 of the Social Security Act), created an optional Medicaid state plan benefit to establish Medicaid health homes to coordinate care for Medicaid beneficiaries who meet the following health criteria: (1) having two or more chronic conditions; (2) having one chronic condition and being risk for a second; or (3) having a serious mental illness.[5] The statute that created the Medicaid health homes program defines chronic conditions to include the following conditions: asthma, diabetes, heart disease, and overweight (a body mass index over 25), in addition to mental health conditions and substance use disorder.[6] Under the statute, states may also propose other conditions to Centers for Medicare & Medicaid Services (CMS). As Medicaid health homes' priority conditions and target populations align closely with those of the Pilot program, ASTHO suggests that the Commission adopt the definition of chronic conditions from the Medicaid health home program and consider these criteria to inform the selection of Pilot program proposals.

Sec. 10. Broadband Connectivity for Providers and/or Patients
The proposed rule considers whether to support funding for the costs of (1) the broadband connectivity that eligible low-income patients of participating hospitals and clinics would use to receive connected care services and (2) the broadband connectivity that a participating hospital or clinic would need to conduct its proposed connected care Pilot project. The rule notes that many patients lack home broadband service to receive connected care services.

ASTHO Comment:
ASTHO applauds the suggestion that the Pilot program provide funding for both broadband for eligible low-income patients as well as broadband for hospitals and clinics. ASTHO supports providing funding for eligible low-income patients to ensure that broadband is accessible to the

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entire region or community. Ensuring that care can be accessed in the home and community setting is fundamental to improving access to care and health outcomes.[7]

Sec. 12: Definition of "Telehealth"
The proposed rule seeks comment on the proposed definitions of "telehealth" (a wide variety of remote health care services beyond the doctor-patient relationship; for example, involving services provided by nurses, pharmacists, or social workers) and "telemedicine" (using broadband internet access service-enabled technologies to support the delivery of medical, diagnostic, and treatment-related services, usually by doctors).

ASTHO Comment:
ASTHO suggests that the Pilot program adopt the definition used by the Health Resources and Services Administration (HRSA). HRSA defines telehealth as "the use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration. Technologies include video conferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications."[8]

The terms "telehealth" and "telemedicine" are often used interchangeably but have different definitions. Telemedicine typically refers to traditional clinical diagnosis and monitoring that is delivered with technological assistance, while telehealth encompasses a broader array of services and uses, including health education.[9] Therefore, ASTHO suggests that the Pilot program use the term "telehealth," because it encompasses a broader array of services, including public health programs, health education, and other non-clinical services—such as social work and counseling—that are critical to improving behavioral health and chronic conditions.[10]

Sec 18. *Other Program Structure Considerations.* Medical Licensing and Reimbursement Laws and Regulations
The proposed rule seeks comment on whether there are medical licensing laws or regulations, or medical reimbursement laws or regulations, that would have a bearing on how the Commission structures the Pilot program. Commenters in the record identify reimbursement as a major barrier to telehealth adoption and urge the Commission to coordinate with CMS to implement reforms to reimbursement policies for telehealth.

ASTHO Comment:
The 2019 ASTHO telehealth capacity survey results showed funding and reimbursement policies to be the most common barrier to advancing telehealth, with nearly a quarter of the 39 S/THA respondents reporting this as their top challenge. The current telehealth reimbursement landscape varies across states and creates a confusing environment for individuals who use telehealth and health systems that provide care across multiple states. For example, there is significant variation across states regarding the types of telehealth modalities that are covered under public and private payers.[11] While all 50 states and Washington, D.C. provide

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reimbursement for some form of live video, only 21 state Medicaid programs reimburse for remote patient monitoring, and only 11 reimburse for store-and-forward telehealth services.[12]

ASTHO suggests the Commission collaborate with CMS to both incentivize and promote Medicaid and Medicare reimbursement policies for telehealth and to mitigate the potential barriers that reimbursement laws or regulations may have on the Pilot program. In particular, ASTHO encourages the Commission to explore promoting telehealth parity among the states. Telehealth parity laws, which have been implemented in 28 states and Washington, D.C., require that health insurance plans provide equivalent coverage for telehealth services and in-person services.[13]

Sec. 28: Eligible Health Care Providers
The Commission proposes to limit health care provider participation in the Pilot program to non-profit or public health care providers within section 254(h)(7)(B): (i) Post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; (ii) community health centers or health centers providing health care to migrants; (iii) local health departments or agencies; (iv) community mental health centers; (v) not-for-profit hospitals; (vi) rural health clinics; (vii) skilled nursing facilities, and others.

ASTHO Comment:
ASTHO supports the Commission's proposal to limit provider participation to non-profit or public health care providers within section 254(h)(7)(B). Specifically, ASTHO applauds the Commission's proposal to provide funding to local health departments, Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes, critical access hospitals, and rural health clinics. In particular, local health departments and FQHCs are critical to improving access to care through expanded telehealth services. Several S/THAs, including Alabama and Georgia, have worked collaboratively with local health departments and FQHCs to improve statewide telehealth capacity by developing telehealth networks.[14] These networks allow safety net providers in areas with provider shortages to act as hubs in a hub-and-spoke model by connecting patients directly to necessary specialists. For example, Georgia's telehealth network connects all 159 of its counties and has expanded access to over 400 providers that patients would otherwise not have access to.[15]

Sec. 48: Additional Proposal Points for Certain Geographic Areas or Populations
The proposed rule suggests that the Commission award additional points to proposed projects that would serve geographic areas or populations where there are well-documented health care disparities (e.g., Tribal lands, rural areas, or veteran populations). In particular, the Commission proposes awarding extra points during the evaluation process to proposals that meet the following requirements: (a) The health care provider is located in a rural area; (b) the project would primarily serve patients who reside in rural areas; (c) the project would serve patients located in five or more Health Professional Shortage areas (for primary care or mental health care only) or Medically Underserved Areas, as designated by HRSA by geography; (d) the health care provider is located on Tribal lands, is affiliated with a Tribe, or is part of the Indian Health Service; or (e) the health care provider would primarily serve patients who are veterans. The Commission

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seeks comment on how these factors should be weighed against one another and whether certain projects should receive additional points for each factor they satisfy.

ASTHO Comment:
ASTHO applauds the Commission's plan to award additional points in the evaluation process to proposed projects that satisfy the factors described above. In particular, ASTHO encourages the Commission to award additional points to proposals that meet the following factors: (a) the health care provider is located in a rural area, (b) the project would primarily serve patients who reside in rural areas, and (d) the health care provider is located on Tribal lands, is affiliated with a Tribe, or is part of the Indian Health Service. Rural areas continue to face the most significant barriers to accessing broadband.[16] These communities face extreme health professional workforce shortages, which contributes to and reinforces existing health disparities.[17] Fewer health care personnel in these areas means that many Americans in rural areas are forced to travel farther and incur greater costs for clinical services than Americans in urban areas, and many delay care, which can lead to worsening health conditions.[18] In addition, individuals in rural areas are more likely to die from chronic conditions, including heart disease, cancer, chronic lower respiratory disease, and stroke, than individuals in urban areas.[19] Further, Tribal communities face high disease burdens and access challenges due to fewer resources, cultural differences, remote geography, and historical distrust of the health care system.[20] Tribal communities also have a high prevalence of and risk factors for diabetes, heart disease, mental health conditions, and substance use disorder.[21]

Sec. 52: Other Health Conditions of Focus
The Commission seeks comment on awarding additional points for projects that are primarily focused on treating health conditions that are considered health crises, including opioid use, mental health conditions, and maternal mortality. The Commission seeks comment on whether there are any other health conditions that would warrant awarding additional points to specific project proposal during the selection process.

ASTHO Comment:
ASTHO encourages the Commission to award additional points to projects that primarily focus on preventing and treating HIV and other sexually transmitted infections. Given the recent advancements in HIV prevention and treatment and the current administration's proposed *Ending the HIV Epidemic: A Plan for America*, focusing on these conditions would be an effective and efficient use of resources.[22] Further, states have developed innovative programs that leverage telehealth for HIV prevention. For example, TelePrEP programs allow individuals to virtually connect with providers to prescribe PrEP in rural and other underserved areas where there is limited access to health care providers.[23,24]

Sec. 71-72: *Proposed Program Goals.* The Commission intends that the Pilot program will help to improve health outcomes. The Commission describes several benefits of this goal, such as the expansion of access to high-level care for those who experience geographical barriers and rural

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challenges, better management of chronic conditions, and increased adherence to prescribed treatment.

ASTHO Comment:
ASTHO supports the proposal to include improvement of health outcomes through connected care as a goal for the Pilot program. It is extremely difficult for those living in rural and underserved regions to access health care services due to provider shortages, hospital closures, lack of transportation, and financial barriers.[25] As was recently exemplified in Macon, Georgia, providing these individuals with access to telehealth services may significantly improve health outcomes. Macon experienced high rates of infant and maternal mortality due to rurality challenges and inaccessibility to services for women and children.[26] After receiving increased funds for telehealth programs, the state launched several telehealth initiatives that provided access to lactation and nutrition education, specialty consultation, and pediatric services for women and children. These telehealth efforts increased access and adherence to care and decreased waiting times, missed appointments, transportation barriers, and health care costs for Georgia residents.[27] By establishing this telehealth network, the George Department of Health was able to address several access challenges contributing to lower health outcomes in the state.

Access to clinical services is also a significant factor that contributes to the social determinants of health. About eighty percent of health outcomes are determined by social and economic factors, such as the places where people live, work, learn, worship, and play.[28,29] ASTHO applauds the Commission for elevating these components and partnering in sectors beyond those FCC traditionally engages to promote models of care that link clinical, community, and social services to achieve optimal health.[30]

Sec. 80: ***Metrics***. The Commission seeks comment on the best metrics and methodologies for measuring progress toward its proposed program goals. For example, are there specific ways in which broadband-enabled telehealth applications can improve health outcomes that could be demonstrated through the Pilot program? In the Notice of Inquiry, the Commission proposed several metrics: Reductions in emergency room or urgent care visits in a particular geographic area or among a certain class of patients; decreases in hospital admissions or re-admissions for a certain patient group; condition-specific outcomes, such as reductions in premature births or acute incidents among sufferers of a chronic illness; and patient satisfaction as to health status. The Commission seeks comment on if other metrics might measure this goal.

ASTHO Comment:
ASTHO cautions against focusing solely on utilization as a measurement of outcomes. ASTHO encourages tracking and measuring outcome indicators, such as death rates and disease incidence and prevalence. Moreover, ASTHO encourages the Commission to include access to health measures in addition to outcomes measures. By focusing on health outcomes and access measures concurrently, the Commission can better understand improvements in quality of care. Access measures can be evaluated in several ways and can provide information on a patient's timely and appropriate access to care. Highlighting health care services as an indicator of health access has been found to be limiting, since medical care is overused and underused for reasons besides access.[31] For example, underserved individuals may be able to enter the health care

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system, but may have difficulty affording services and treatment, which could result in inadequate access and care.

Sec. 86: *Reporting Intervals.* The Commission seeks comment on the required reporting intervals (e.g. quarterly or annually) and the information that should be included in the reports. The Commission seeks comment on whether quarterly intervals would be sufficient and whether there are shorter or longer reporting intervals that would be more appropriate when analyzing outcomes from clinical trials.

ASTHO Comment:
ASTHO cautions that data will not be able to show improvements in outcomes over a short timeframe; therefore, constructing reporting requirements that are mindful of establishing baseline data and progress toward improving the baseline data should be paramount. More frequent reporting requirements may increase the burden on the reporters. ASTHO encourages the Commission to consider developing a data repository or other online platform, system, or shared site for housing data so that as results are collected, all users have access.

Sec. 87: *Clinical Trials*. The proposed rule seeks comment on the appropriate methods for measuring the health effects of the connected care Pilot projects. If the proposed treatment in a Pilot project has already been extensively studied and the health benefits are generally accepted by the medical community, and the Pilot's purpose is to uncover other effects, such as the impact on the costs of providing health care or the broader impacts of subsidized access to broadband Internet access services for connected care, is there any need to require the reporting of health outcomes? Should all projects be required to conduct randomized controlled trials to determine the effect of the treatments on patients' health? Are there alternative, less costly methods that are statistically sound and can accurately measure the effect of the treatment? Are these alternative methods generally accepted in the scientific and medical communities?

ASTHO Comment:
ASTHO underscores that if the Pilot program aims to improve health outcomes, it is fundamentally important to require health outcome reporting. Improvement in health outcomes, such as lower incidence and prevalence of health conditions, should be measured in tandem with increased access to health care services through telehealth via broadband internet.

ASTHO recommends working with academic health centers to discern what types of cost-effective research studies may be the most statistically sound and best supported. Longitudinal studies or cross-sectional studies may be additional alternatives to explore, as they are generally accepted as rigorous in the scientific and medical communities. The *New England Journal of Medicine* recommends the following with respect to data collection: "The regulation expands the requirements for submitting results information to include any baseline information on race and ethnic background that was assessed. This requirement is consistent with scientific interest in the inclusion of minorities in clinical trials and in the generalizability of research findings. In addition, the rule requires the reporting of any other measures assessed at baseline that are used in

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analyzing a primary outcome measure (e.g., baseline measure of blood pressure for a primary outcome measure of change in blood pressure). This requirement is designed to help ensure that results information for the primary outcome measure can be properly interpreted."[32]

Sec. 92: The Commission seeks comment on whether regular reports from each Pilot project should be made publicly available and where the best place is to host this information. The Commission asks if it should allow project participants to request delay of publication until the project is completed if publication might impact the experiment. All data from Pilot program participants will be anonymized and aggregated, but the Commission seeks comment on HIPAA or other privacy concerns for best ways to ensure proper data protection and sensitivity. Further, the Commission asks whether there are other privacy or security measures that the Commission and USAC should take to ensure proper receipt, storage, and use of the data.

ASTHO Comment:
ASTHO supports public availability and data sharing where possible. Where applicable, ASTHO recommends working with a S/THA when disseminating data or reports, given their exempt status under HIPAA as a public health authority.[33,34,35,36] The data should be aggregated and anonymized and follow both HIPAA and state laws regarding protected health information and privacy. In addition, all privacy and security measures of the hosting agency (e.g., the S/THA) should be followed. Often, state and territorial health agencies will already have an existing data sharing and stewardship policy.

Thank you for the opportunity to comment on the proposed rule. If you have any questions or would like additional information, please contact Deborah Fournier (dfournier@astho.org), senior director of clinical to community connections at ASTHO's Center for Population Health Strategies.

Sincerely,

Michael Fraser, PhD, CAE
Chief Executive Officer, ASTHO

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